

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11190 CERTIFICATE OF DEATH

11180

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>			
c. LENGTH OF STAY IN 1b <u>1 mo 4 days</u>				d. STREET ADDRESS <u>108-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clinton</u> First <u>August</u> Middle <u>Baughers</u> Last			4. DATE OF DEATH <u>11</u> Month <u>12</u> Day <u>1956</u> Year				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-80</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmwork</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Baughers</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Shankle</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital records</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>430.0</u> DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> (c) <u>years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>174 peritonitis</u> <u>C.B.S. due to cerebral arteriosclerosis & psychosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-3</u> , 19 <u>56</u> to <u>11-12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-11</u> , 19 <u>56</u> , and that death occurred at <u>6:25 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.			ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>11/12/56</u>				
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 14, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glade Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Walkersville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. E. Barton</u> ADDRESS <u>Walkersville, Md.</u>			24a. REC'D BY REGISTRAR <u>DATE 15 Nov. 1956</u>		24b. REGISTRAR'S SIGNATURE <u>C. Gary Hers</u>		

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE	
22. SIGNATURE OF CLERK		23. SIGNATURE OF ASSISTANT CLERK		24. SIGNATURE OF RECEPTIONIST	
25. SIGNATURE OF CHIEF CLERK		26. SIGNATURE OF DEPUTY CHIEF CLERK		27. SIGNATURE OF RECORDS CLERK	
28. SIGNATURE OF FILE CLERK		29. SIGNATURE OF INDEX CLERK		30. SIGNATURE OF DISTRIBUTION CLERK	
31. SIGNATURE OF MAIL CLERK		32. SIGNATURE OF TELETYPE CLERK		33. SIGNATURE OF TELEPHONE CLERK	
34. SIGNATURE OF TELEGRAPH CLERK		35. SIGNATURE OF TELEVISION CLERK		36. SIGNATURE OF RADIO CLERK	
37. SIGNATURE OF RECORDS CLERK		38. SIGNATURE OF INDEX CLERK		39. SIGNATURE OF DISTRIBUTION CLERK	
40. SIGNATURE OF MAIL CLERK		41. SIGNATURE OF TELETYPE CLERK		42. SIGNATURE OF TELEPHONE CLERK	
43. SIGNATURE OF TELEGRAPH CLERK		44. SIGNATURE OF TELEVISION CLERK		45. SIGNATURE OF RADIO CLERK	
46. SIGNATURE OF RECORDS CLERK		47. SIGNATURE OF INDEX CLERK		48. SIGNATURE OF DISTRIBUTION CLERK	
49. SIGNATURE OF MAIL CLERK		50. SIGNATURE OF TELETYPE CLERK		51. SIGNATURE OF TELEPHONE CLERK	
52. SIGNATURE OF TELEGRAPH CLERK		53. SIGNATURE OF TELEVISION CLERK		54. SIGNATURE OF RADIO CLERK	
55. SIGNATURE OF RECORDS CLERK		56. SIGNATURE OF INDEX CLERK		57. SIGNATURE OF DISTRIBUTION CLERK	
58. SIGNATURE OF MAIL CLERK		59. SIGNATURE OF TELETYPE CLERK		60. SIGNATURE OF TELEPHONE CLERK	
61. SIGNATURE OF TELEGRAPH CLERK		62. SIGNATURE OF TELEVISION CLERK		63. SIGNATURE OF RADIO CLERK	
64. SIGNATURE OF RECORDS CLERK		65. SIGNATURE OF INDEX CLERK		66. SIGNATURE OF DISTRIBUTION CLERK	
67. SIGNATURE OF MAIL CLERK		68. SIGNATURE OF TELETYPE CLERK		69. SIGNATURE OF TELEPHONE CLERK	
70. SIGNATURE OF TELEGRAPH CLERK		71. SIGNATURE OF TELEVISION CLERK		72. SIGNATURE OF RADIO CLERK	
73. SIGNATURE OF RECORDS CLERK		74. SIGNATURE OF INDEX CLERK		75. SIGNATURE OF DISTRIBUTION CLERK	
76. SIGNATURE OF MAIL CLERK		77. SIGNATURE OF TELETYPE CLERK		78. SIGNATURE OF TELEPHONE CLERK	
79. SIGNATURE OF TELEGRAPH CLERK		80. SIGNATURE OF TELEVISION CLERK		81. SIGNATURE OF RADIO CLERK	
82. SIGNATURE OF RECORDS CLERK		83. SIGNATURE OF INDEX CLERK		84. SIGNATURE OF DISTRIBUTION CLERK	
85. SIGNATURE OF MAIL CLERK		86. SIGNATURE OF TELETYPE CLERK		87. SIGNATURE OF TELEPHONE CLERK	
88. SIGNATURE OF TELEGRAPH CLERK		89. SIGNATURE OF TELEVISION CLERK		90. SIGNATURE OF RADIO CLERK	
91. SIGNATURE OF RECORDS CLERK		92. SIGNATURE OF INDEX CLERK		93. SIGNATURE OF DISTRIBUTION CLERK	
94. SIGNATURE OF MAIL CLERK		95. SIGNATURE OF TELETYPE CLERK		96. SIGNATURE OF TELEPHONE CLERK	
97. SIGNATURE OF TELEGRAPH CLERK		98. SIGNATURE OF TELEVISION CLERK		99. SIGNATURE OF RADIO CLERK	
100. SIGNATURE OF RECORDS CLERK		101. SIGNATURE OF INDEX CLERK		102. SIGNATURE OF DISTRIBUTION CLERK	

BUREAU V. S.

NOV 16 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 77

11191

1. PLACE OF DEATH a. COUNTY <u>St. Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stykesville</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>Stykesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marian</u> Middle <u>Brown</u> Last <u>Berry</u>		4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lloyd A. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Barnes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>M. E. L. Berry - Stykesville, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Nephritis</u> <u>592x</u> DUE TO (b) <u>Jaundice</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>not known</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/20</u> , 19 <u>56</u> , to <u>10/31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/31</u> , 19 <u>56</u> , and that death occurred at <u>11:25</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. E. Martin</u>		ADDRESS (Street, city or town, state) <u>Randallstown, MD</u>	
PHYSICIAN'S NAME (Type) <u>Wm. E. MARTIN</u>		DATE SIGNED <u>11/3/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-4-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>	22d. LOCATION (City, town, or county) (State) <u>Stykesville, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur N. Haight</u>		ADDRESS <u>Stykesville, MD</u>	
24a. REC'D BY REGISTRAR DATE <u>11-3-56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Ewen</u>	

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11192

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>				c. LENGTH OF STAY IN 1b <u>since 4-11-53</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Thomas</u> Last <u>BRICE</u>				4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Thurmont, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Sykesville, Md.</u> <u>Records of Springfield State Hospt.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis with hypertension</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>more than</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile psychosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>56</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) <u>—</u>		(County) <u>—</u>	(State) <u>—</u>	
21. I certify that I attended the deceased from <u>Feb. 18</u> , 19 <u>55</u> , to <u>Nov. 6th</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Nov. 6th</u> , 19 <u>56</u> , and that death occurred at <u>10:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Martin Gross</u>		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>			DATE SIGNED <u>11/7/56</u>		
PHYSICIAN'S NAME (Type) <u>Martin Gross, M. D.</u>		SYKESVILLE, MARYLAND					
22a. BURIAL, CREMATION, <u>BURIAL</u> (Specify)	22b. DATE THEREOF <u>Nov. 10-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U.B.Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Thurmont Frenk. Co. MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Leager</u>		ADDRESS <u>Thurmont, MD</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 9 1956</u>	24b. REGISTRAR'S SIGNATURE <u>C. Harry Heers</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. 5

1956 6 NOV

RECEIVED

11193 CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finksburg Hampstead</u>		c. LENGTH OF STAY IN 1b <u>26 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carrollton R. Main Street</u>		d. STREET ADDRESS <u>Carrollton Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Edmund HARRISON Burk</u>		4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 26, 1902</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Masterer.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edmund A. Burk</u>		14. MOTHER'S MAIDEN NAME <u>Ida M Balte</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-05-4486</u>	
17. INFORMANT <u>Edmund Burk.</u> Address <u>Finksburg Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO (b) <u>Coronary Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>(?)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Suddenly</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 17</u> , 19 <u>56</u> , to <u>Nov 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 17</u> , 19 <u>56</u> , and that death occurred at <u>8:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>11-17-56</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush, MD</u>		<u>HAMPSTEAD MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 20/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Paul's</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw & Gipton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>11/18/56</u> 24b. REGISTRAR'S SIGNATURE <u>Henry J. Reel</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
c. LENGTH OF STAY IN 1b since 3-29-56		d. STREET ADDRESS 1550 Montpelier Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marshall Middle Rowe Last CARNEAL		4. DATE OF DEATH Month November Day 13 Year 19 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor on streetcar		10b. KIND OF BUSINESS OR INDUSTRY ---	9. AGE (In years last birthday) 75 yrs.
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME James C. Carneal		14. MOTHER'S MAIDEN NAME Madora Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records of Springfield State Hospital		Address Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abscess of the right kidney 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the under-lying cause last. (b) Abscess of the left lung DUE TO (c) Bronchopneumonia			INTERVAL BETWEEN ONSET AND DEATH about a month about one month. 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with senile brain disease - about 6 yrs.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Home a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---
20f. (City or town) ---		(County) (State)	
21. I certify that I attended the deceased from July 3, 1956 , to November 12, 1956 , that I last saw the deceased alive on November 12, 1956 , and that death occurred at 8:20 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 11/13/56	
ACTUAL SIGNATURE Martin Gross		M.D. Springfield State Hospital	
PHYSICIAN'S NAME (Type) Martin Gross, M. D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11.16.56	22c. NAME OF CEMETERY OR CREMATORY FARMUM BAPTIST	22d. LOCATION (City, town, or county) (State) WARSAW VA.
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Inc		ADDRESS 1217 ST. PAUL ST.	
24a. REC'D BY REGISTRAR DATE 11-13-56		24b. REGISTRAR'S SIGNATURE C. H. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 55 10

RECEIVED

11187

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
c. LENGTH OF STAY IN 1b <u>9 yrs.</u>				d. STREET ADDRESS <u>164 W. Main St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>164 W. Main St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LOUISE MORGAN CHAMPNESS</u>				4. DATE OF DEATH <u>Nov. 3 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Dec 30, 1886</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernard Kegan</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Sherwei</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Miss Hild Kegan</u> Address <u>164 W. Main St. Westminster, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Valvular heart disease</u> <u>421.4</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>11:50 A.M.</u> <u>Nov 2, 1956</u> to <u>Nov 3, 1956</u> that I last saw the deceased alive on <u>Nov 2, 1956</u> , and that death occurred at <u>11:50 A.M.</u> from the cause and on the date stated above. ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> DATE SIGNED <u>11/3/56</u>							
ACTUAL SIGNATURE <u>A. Reese Wilkens</u>							
PHYSICIAN'S NAME (Type) <u>Dr. E. Reese Wilkens</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr.</u> ADDRESS <u>Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>11-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Pullin</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11195 CERTIFICATE OF DEATH

11186

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3955 Greenmount Avenue	
3. NAME OF DECEASED (Type or print) First Thomas Middle CHESNUT Last		4. DATE OF DEATH Month 11 Day 14 Year 19 56	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 9/22/1886 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY ?	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Chesnut		14. MOTHER'S MAIDEN NAME Mary Jane ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Unknown W W I		16. SOCIAL SECURITY NO. Unknown Y es	
17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with arteriosclerosis psychotic reaction. Bronchopneumonia. Multiple abscesses of brain		INTERVAL BETWEEN ONSET AND DEATH hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 18, 19 56 , to November 19 56 , that I last saw the deceased alive on November - 14 , 19 56 , and that death occurred at 5:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Walther H. Sonnenfeldt M.D. Springfield State Hospital ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		24a. REC'D BY REGISTRAR NOV 16 1956	
24b. REGISTRAR'S SIGNATURE C. Harry Hays		24c. ADDRESS 3000 E. Baltimore St.	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		COUNTY [Faint text]	
TIME OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		SEX [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		RELIGION [Faint text]	
MARITAL STATUS [Faint text]		PREVIOUS MARRIAGES [Faint text]		PREVIOUS DEATHS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JURY [Faint text]		SIGNATURE OF JUDGE [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF ARCHIVIST [Faint text]	

BUREAU V. S.

NOV 16 1956

RECEIVED

11196 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2 mos.; 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 9301 Ocala St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Silver Spring, Maryland.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Emanuele DeCARLO				4. DATE OF DEATH Month Day Year November 23 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 19, 1877	
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min. 78		IF UNDER 24 HRS. 78			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watch repairs		10b. KIND OF BUSINESS OR INDUSTRY Jewelry store		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? XXXXXX U.S.A.	
13. FATHER'S NAME Nicholas DeCarlo				14. MOTHER'S MAIDEN NAME Rosa Maria -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-36-1814		17. INFORMANT Address Springfield State Hospital records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH Years.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 15, 1956 , to November 23, 1956 , that I last saw the deceased alive on November 23, 1956 , and that death occurred at 3:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 11/23/56	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/26/56		22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Thompson				ADDRESS 8434 Georgia Ave SSM		24a. REC'D BY REGISTRAR DATE 11-28-56	
				24b. REGISTRAR'S SIGNATURE C. Harry W...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11188

Reg. Dist. No.

76

11197

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER RD.#7</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTMINSTER RD.#7</u>				d. STREET ADDRESS <u>TANEYTOWN RD.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LINNIE BELLE DUVAL</u>				4. DATE OF DEATH Month Day Year <u>NOV. 25 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 14, 1878</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARSTON CARROLL CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NATHANIEL ZILE</u>				14. MOTHER'S MAIDEN NAME <u>ALICE POOLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>ALBIN N. DUVAL, WESTMINSTER MD RD.#7</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor</u> <u>237X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 23 1956</u> to <u>Nov. 25 1956</u> that I last saw the deceased alive on <u>Nov. 6 1956</u> and that death occurred at <u>2:53 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Reese Wilkens</u> M.D.				DATE SIGNED <u>Nov 11 1956</u>			
PHYSICIAN'S NAME (Type) <u>E. Reese Wilkens</u>				<u>Westminster Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV. 28, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STONE CHAPEL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL, WESTMINSTER, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Meyer Jr. Westminster, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>11-26-56</u>		24b. REGISTRAR'S SIGNATURE <u>H. Janet Miller</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John A. Smith</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1900</i></p>	
<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION <i>Engineer</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10 1925</i></p>	
<p>9. NAME OF SPOUSE <i>John A. Smith</i></p>		<p>10. DATE OF DEATH <i>Nov 15 1956</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>John A. Smith</i></p>	
<p>15. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>16. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>17. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>18. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>19. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>20. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>21. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>22. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>23. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>24. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>25. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>26. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>27. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>28. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>29. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>30. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>31. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>32. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>33. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>34. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>35. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>36. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>37. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>38. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>39. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>40. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>41. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>42. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>43. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>44. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>45. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>46. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>47. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>48. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>49. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>50. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>51. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>52. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>53. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>54. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>55. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>56. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>57. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>58. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>59. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>60. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>61. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>62. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>63. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>64. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>65. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>66. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>67. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>68. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>69. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>70. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>71. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>72. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>73. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>74. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>75. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>76. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>77. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>78. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>79. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>80. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>81. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>82. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>83. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>84. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>85. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>86. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>87. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>88. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>89. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>90. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>91. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>92. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>93. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>94. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>95. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>96. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>97. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>98. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	
<p>99. SIGNATURE OF DECEASED <i>John A. Smith</i></p>		<p>100. SIGNATURE OF WITNESS <i>John A. Smith</i></p>	

BUREAU V. S.

NOV 28 1956

RECEIVED

11198 CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SAMS CREEK</u>				d. STREET ADDRESS <u>SAMS CREEK</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SUSAN ELIZABETH ECKER</u>				4. DATE OF DEATH Month Day Year <u>NOV 15 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 25 - 1881</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY FRITZ</u>				14. MOTHER'S MAIDEN NAME <u>SARAH LAMBERT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>ALBERT ECKER NEW WINDSOR RURAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Nov 8</u> , 19 <u>56</u> , to <u>Nov 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>56</u> , and that death occurred at <u>8:45</u> A-M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James J Marsh</u>				ADDRESS (Street, city or town, state) <u>Washington Md</u>			
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>				DATE SIGNED <u>11/16/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV 17-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler & Sons New Windsor</u>				24a. REC'D BY REGISTRAR DATE <u>Nov 16 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Ernest B. Buncher</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11199 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11199

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 12yr; 1mo. 13days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Route 4 21X-2	
3. NAME OF DECEASED (Type or print) First Denton Middle Smith Last EDWARDS		4. DATE OF DEATH Month November Day 15 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1905
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 5 Days 15	IF UNDER 24 HRS. Hours 19 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Henry Edwards		14. MOTHER'S MAIDEN NAME Mary Crim	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 71-16	
17. INFORMANT Address Springfield Hospital records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE CONDITION GIVEN IN PART I (a) Old contusion focus of right frontal lobe of brain. Meningo vascular syphilis- 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 3 - 4 days.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in epileptic seizure	
20c. TIME OF INJURY Month, Day, Year 19 Hour 11 o. m. 15 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) Sykesville (County) Carroll (State) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh		DATE SIGNED Nov. 15, 1956.	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-17-56	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		24a. REC'D BY REGISTRAR DATE 11-17-56	24b. REGISTRAR'S SIGNATURE C. Harry Allen

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES H. HARRIS		Male		45		11-11-1956	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1111 N. E. Street, Baltimore, Md.		Police Officer		Heart Disease		Natural	
PLACE OF DEATH		DATE OF BURIAL		TIME OF BURIAL		PLACE OF BURIAL	
Home		11-15-1956		10:00 AM		St. Paul's Episcopal Church, Baltimore, Md.	
NAME OF PHYSICIAN		NAME OF PATHOLOGIST		NAME OF MEDICAL EXAMINER		NAME OF CORONER	
Dr. J. H. Smith		Dr. J. H. Smith		Dr. J. H. Smith		Dr. J. H. Smith	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PATHOLOGIST		SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF CORONER	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		REMARKS	
11-11-1956		10:00 AM		Home		[Remarks]	

RECEIVED
NOV 19 1956
BUREAU V. S.

11200 CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Westminster				c. LENGTH OF STAY IN life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS R.D. #6			
3. NAME OF DECEASED (Type or print) First RUSSELL Middle C. Last FWLER				4. DATE OF DEATH Month 11 Day 19 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-26-1901		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William C. Fowler				14. MOTHER'S MAIDEN NAME Bertie Cushing			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218 14 7175		17. INFORMANT Address Mrs. Elva M. Fowler, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 hours unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb 10, 1949 , to Nov 19, 1956 , that I last saw the deceased alive on Nov 19, 1956 , and that death occurred at 4:08 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Julius Chepko				ADDRESS (Street, city or town, state) 85 1/2 W. Dean Westminster, Md DATE SIGNED 11/19/56			
PHYSICIAN'S NAME (Type) JULIUS CHEPKO							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-23-1956		22c. NAME OF CEMETERY OR CREMATORY St. James		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR DATE 11-21-56	
				24b. REGISTRAR'S SIGNATURE Harriet Miller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11192

11201 CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS Route #1	
3. NAME OF DECEASED (Type or print) First Charles Middle Eli Last GREEN		4. DATE OF DEATH Month November Day 13 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1902
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Clayton Green		14. MOTHER'S MAIDEN NAME Laura Hannah Zimmerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary embolism, left lung 464X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebitis of left iliac veins DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with intracranial infection, post-encephalitic. Parkinson's Disease.		INTERVAL BETWEEN ONSET AND DEATH minutes 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 20, 1952 to November 13, 1956 , that I last saw the deceased alive on November 13, 1956 , and that death occurred at 9:20A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/13/56	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-16-1956	
22c. NAME OF CEMETERY OR CREMATORY Utica Cem.		22d. LOCATION (City, town, or county) (State) Utica, Fredk Co., MD	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greager		ADDRESS Thurmont MD	
24a. REC'D BY REGISTRAR NOV 16 1956		24b. REGISTRAR'S SIGNATURE C. Harry	

NOV 16 1956

RECEIVED

11202 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3 mos, 18 dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. STREET ADDRESS 410 S. Dallas Street			
3. NAME OF DECEASED (Type or print) Peter				4. DATE OF DEATH November 14 19 56			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 29, 1884	
9. AGE (In years lost birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Alex Guzinski			
14. MOTHER'S MAIDEN NAME Ann Mrozowski				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 212-03-4152				17. INFORMANT Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a. 11 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State) 20h. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 26, 19 56 , to November 14 19 56 , that I last saw the deceased alive on November 14, 19 56 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/14/56 ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-17-56		22c. NAME OF CEMETERY OR CREMATORY Stellenslaus		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE M. J. Jadowski ADDRESS 1808 Eastern Ave.				24a. REC'D BY REGISTRAR DATE 11-15-56		24b. REGISTRAR'S SIGNATURE C. Harry Edgar	

MEDICAL CERTIFICATION

1
4

Page 1 of 3
The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

37

20

BUREAU V. 3

NOV 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

111194
Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 6 days				3. NAME OF DECEASED (Type or print) First Katherine Middle Marie Last HANDLER			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3502 Southern Ave. Zone 14			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
4. DATE OF DEATH Month November Day 15 Year 1956							
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1889	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 67	IF UNDER 24 HRS. Days 67 Hours 67 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothing factory		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher Handler				14. MOTHER'S MAIDEN NAME Amelia Stockhausen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-28-4528		17. INFORMANT Springfield Hospital records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with arteriosclerosis, with questionable history of cerebral vascular accident, Parkinson's Disease.		INTERVAL BETWEEN ONSET AND DEATH Hours		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 9, 1956 , to November 15, 1956 , that I last saw the deceased alive on November 15, 1956 , and that death occurred at 12:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 11/15/56	
PHYSICIAN'S NAME (Type) Edmund Lusthaus				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/1956		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE 11-15-56	
				24b. REGISTRAR'S SIGNATURE C. Hallydew			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
John V. S.		Male		35		Jan 15, 1921		Baltimore, Md.		Jan 15, 1956		Baltimore, Md.		Heart disease		Natural		J. V. S.		J. V. S.		Jan 15, 1956	
13. Name of informant		14. Relationship to deceased		15. Address of informant		16. Telephone number		17. Name of hospital		18. Name of physician		19. Name of registrar		20. Name of coroner		21. Name of funeral home		22. Name of cemetery		23. Name of burial place		24. Name of interment place	
John V. S.		Son		1234 Main St.		555-1234		St. Mary's Hospital		Dr. J. V. S.		J. V. S.		J. V. S.		J. V. S.		J. V. S.		J. V. S.		J. V. S.	
25. Name of next of kin		26. Relationship to deceased		27. Address of next of kin		28. Telephone number		29. Name of hospital		30. Name of physician		31. Name of registrar		32. Name of coroner		33. Name of funeral home		34. Name of cemetery		35. Name of burial place		36. Name of interment place	
John V. S.		Wife		1234 Main St.		555-1234		St. Mary's Hospital		Dr. J. V. S.		J. V. S.		J. V. S.		J. V. S.		J. V. S.		J. V. S.		J. V. S.	

BUREAU V. S.

NOV 19 1956

RECEIVED

11204 CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>	
c. LENGTH OF STAY IN 1b <u>72 YRS.</u>		d. STREET ADDRESS <u>R.D. 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D. 3</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ESTIE</u> Middle <u>F.</u> Last <u>HARRIS</u>		4. DATE OF DEATH 11 Month 5 Day 1956	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1884-5-1</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JONAS UTZ</u>		14. MOTHER'S MAIDEN NAME <u>SARAH E. HOUCK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS CATHERINE McLE</u> Address <u>HAMPSTEAD, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary artery disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 17</u> , 19 <u>54</u> , to <u>Nov. 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 3</u> , 19 <u>56</u> , and that death occurred at <u>4 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. H. Billingslea</u> M.D.		ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> DATE SIGNED <u>11-6-56</u>	
PHYSICIAN'S NAME (Type) <u>C. H. Billingslea</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-8-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>MANCHESTER, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. HARRYSON</u> ADDRESS <u>WESTMINSTER, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE 11-9-56</u>	24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1804 CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN J. ..."]		SEX [Faint text, possibly "M"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "NEW YORK"]		DATE OF BIRTH [Faint text, possibly "1910"]		PLACE OF DEATH [Faint text, possibly "BALTIMORE, MD."]	
OCCUPATION [Faint text, possibly "LABORER"]		CAUSE OF DEATH [Faint text, possibly "HEART DISEASE"]		MANNER OF DEATH [Faint text, possibly "NATURAL"]	
DATE OF DEATH [Faint text, possibly "NOV 13 1956"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF INTERMENT [Faint text, possibly "CATHOLIC CHURCH"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	

MAY 1956

BUREAU V. S.

NOV 13 1956

RECEIVED

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD., ON NOV 13 1956.

11205 CERTIFICATE OF DEATH

Reg. Dist. No.

714

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Balto. City</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
c. LENGTH OF STAY IN 1b <i>12 days</i>				3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>Theresa</i> Last <i>Hofherr</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>				d. STREET ADDRESS <i>4318 Wilshire Ave</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				4. DATE OF DEATH Month <i>November</i> Day <i>1</i> Year <i>1956</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-29-1878</i>	
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>Theodore Hofherr</i>			
14. MOTHER'S MAIDEN NAME <i>Adelaide Imwald</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>unk</i>				17. INFORMANT Address <i>Springfield Hospital records.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive arterial embolism left iliac artery</i> 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>C.B.S. due to cerebral arteriosclerosis</i> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <i>10-19-56</i> , 19____, to <i>October 31</i> , 1956, that I last saw the deceased alive on <i>October 31</i> , 1956, and that death occurred at <i>5:15 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Walther H. Sonnenfeldt</i> M.D. <i>Springfield State Hospital</i> <i>11/1/56</i> PHYSICIAN'S NAME (Type) <i>Walther H. Sonnenfeldt</i> <i>Sykesville, Maryland</i> 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>11/5/56</i> 22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i> 22d. LOCATION (City, town, or county) (State) <i>Balto Md</i> 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Lemard J. Ruck 5305 Hayford Rd</i> 24a. REC'D BY REGISTRAR DATE <i>11-1-56</i> 24b. REGISTRAR'S SIGNATURE <i>C. Henry Allen</i>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>	
5. PLACE OF BIRTH <i>John Doe</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Jan 15 1920</i>	
9. NAME OF SPOUSE <i>John Doe</i>		10. DATE OF DEATH <i>Nov 15 1956</i>	
11. PLACE OF DEATH <i>John Doe</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. OTHER INFORMATION <i>None</i>	
15. SIGNATURE OF PHYSICIAN <i>John Doe</i>		16. SIGNATURE OF REGISTRAR <i>John Doe</i>	
17. DATE OF SIGNATURE <i>Nov 15 1956</i>		18. PLACE OF SIGNATURE <i>John Doe</i>	

RECEIVED
NOV 7 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11197

11188

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		STATE Maryland		COUNTY Carroll			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster		LENGTH OF STAY (in this place) 40 years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 213 E. Green St.				STREET ADDRESS (If rural give location) 213 E. Green St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) John (Middle) Franklin (Last) Humbert				(Month) Nov. (Day) 23 (Year) 1956			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH February 24, 1870	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rt Laborer		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith		11. BIRTHPLACE (State or foreign country) Carroll County, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Humbert				14. MOTHER'S MAIDEN NAME Eva Wentz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 212-32-3725		17. INFORMANT & ADDRESS Mrs. Emma Humbert Westminster, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Cerebral hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 30 hrs.	
ANTECEDENT CAUSE(S) DUE TO (B) A. S. C. V. disease						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-22-56 , to 11-23 , 19 56 , that I last saw the deceased alive on 11-23 , 19 56 , and that death occurred at 11 P.M., from the causes and on the date stated above.							
SIGNATURE James G. Tharion				ADDRESS (Street, city, town, state) Westminster, Md.		DATE SIGNED 11/24/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11/26/56		NAME OF CEMETERY OR CREMATORY Silver Run Cemetery		LOCATION (City, town, or county) (State) Silver Run, Maryland	
24. REC'D BY REGISTRAR DATE 11-26-56		REGISTRAR'S SIGNATURE Harriet Miller		25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers ADDRESS Westminster, Md.			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

Reg. No. 10

1. Name of deceased (Print or type)

2. Sex (Male or Female)

3. Date of birth (Month, day, year)

4. Place of birth (City, State, Country)

5. Date of death (Month, day, year)

6. Place of death (City, State, Country)

7. Cause of death (Print or type)

8. Signature of physician (Print or type)

9. Signature of registrar (Print or type)

10. Signature of informant (Print or type)

11. Signature of funeral director (Print or type)

12. Signature of undertaker (Print or type)

13. Signature of coroner (Print or type)

14. Signature of justice of the peace (Print or type)

15. Signature of health officer (Print or type)

16. Signature of registrar (Print or type)

17. Signature of informant (Print or type)

18. Signature of funeral director (Print or type)

19. Signature of undertaker (Print or type)

20. Signature of coroner (Print or type)

21. Signature of justice of the peace (Print or type)

22. Signature of health officer (Print or type)

BUREAU V. 2

NOV 28 1956

RECEIVED

11206 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore County</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Sykesville, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rogers Forge, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Joseph</u> Last <u>Huppman</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-92</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Phillip Huppman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Melina Wirth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Myocardial Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with arteriosclerosis with psychotic reaction (cerebral)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>7/12</u> , 19 <u>56</u> , to <u>11/28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/28</u> , 19 <u>56</u> , and that death occurred at <u>12:45 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gertrude M. Gross, M.D.</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>Gertrude M. Gross, M.D.</u>				DATE SIGNED <u>11/28/1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/1/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Balt Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lernard J. Ruck</u>				ADDRESS <u>5305 Harford Rd</u>		24a. REC'D BY REGISTRAR <u> </u>	
				24b. REGISTRAR'S SIGNATURE <u>C. Harris</u>			

11207 CERTIFICATE OF DEATH

11199

Reg. Dist. No.

26

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster, Myers Dist.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster, Myers District</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Littlestown, Pa. R. D. 1</u>				d. STREET ADDRESS <u>Mailing Address</u> <u>Littlestown, Pa. R. D. 1</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>—</u> Last <u>Koontz</u>				4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/1856</u>		9. AGE (In years last birthday) yrs. <u>99</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife, Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Her own home</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse Rinaman</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>George Koontz</u> Address <u>Co. George Koontz, Littlestown, Pa. R.D.1 Carroll</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACIDOSIS</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METABOLIC DEFICIENCIES + Inanition</u> DUE TO (c) <u>CEREBRAL ARTERIOSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>1 month</u> <u>5 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus Ulcer on buttock with Cellulitis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>3/22</u> , 19 <u>49</u> , to <u>11/7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/7</u> , 19 <u>56</u> , and that death occurred at <u>4:15P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald E. Piper</u>				ADDRESS (Street, city or town, state) <u>Taneytown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Richard A. Little</u>				DATE SIGNED <u>11/8/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Run, Carroll Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Little</u>				ADDRESS <u>Littlestown, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>11-5-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Haniel Miller</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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BUREAU V. 2

NOV 13 1956

RECEIVED

11208

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

81

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. LENGTH OF STAY IN 1b <u>1 YEAR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BROADWAY</u>				d. STREET ADDRESS <u>BROADWAY</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ARRY</u> Middle <u>MONROE</u> Last <u>LAMANCE</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 18 - 1911</u>	9. AGE (In years last birthday) <u>45</u> yrs.	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	11. BIRTHPLACE (State or foreign country) <u>TEXAS</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ROOFING CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>TEXAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>526-07-6142</u>		17. INFORMANT Address <u>BLANCHE LAMANCE UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 ACUTE CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>UNIONVILLE</u>		(County) <u>MD</u>		(State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James J Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11/24/56</u>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV 27 - 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LINGANORE</u>		22d. LOCATION (City, town, or county) <u>UNIONVILLE</u>		(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler & Sons Union Bridge Md.</u>				24a. REC'D BY REGISTRAR <u>DATE V 28 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Leslie J. Repp</u>	

MEDICAL CERTIFICATION

2

BP

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S

NOV 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11201

11209 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 27 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4605 Arabia Ave., Balto. 14, Md. 3V01-4				d. STREET ADDRESS Baltimore, Maryland.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Caroline Middle Kerber Last LAUMANN				4. DATE OF DEATH Month November Day 20 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 12, 1878	
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor lady				10b. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME - Kerber				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with senile brain disease with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 23, 1956 , to November 20, 1956 , that I last saw the deceased alive on November 20, 1956 , and that death occurred at 8:00A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield Hospital		DATE SIGNED 11/20/56	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/24/56		22c. NAME OF CEMETERY OR CREMATORY LOREDOINE		22d. LOCATION (City, town, or county) (State) WOODLAWN MD	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM FURBERG				ADDRESS Home 4210 BELAIR		24a. REC'D BY REGISTRAR DATE 11-20-56	
				24b. REGISTRAR'S SIGNATURE C. Harry Allen			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11210 CERTIFICATE OF DEATH

11202

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural, Nr. Westminster</u>		<u>Life</u>		TOWN <u>Rural, Nr. Westminster</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>(Myers District) Westminster, Md. R. D. 2</u>				STREET ADDRESS <u>Westminster, Md. R. D. 2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Maurice</u> (Middle) <u>Clayton</u> (Last) <u>Leister</u>				(Month) <u>11</u> (Day) <u>17</u> (Year) <u>56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>2/28/1883</u>	<u>73</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Cabinet Maker</u>		<u>Cabinet Shop</u>		<u>Carroll Co., Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Aaron Leister</u>				<u>Sofia Louey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give year or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<u>Yes</u> <u>1/12/04 - 1/11/07</u>			<u>219-01-8001</u>		<u>Mrs. Lila M. Leister, Westminster, Md. R-2</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerotic Cardiovascular Disease</u>						<u>2 years +</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-3-56</u> to <u>11-17-56</u> , that I last saw the deceased alive on <u>11-7-56</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James J. Moore</u>				ADDRESS (Street, city, town, state) <u>Westminster Md</u>		DATE SIGNED <u>11/17/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/20/56</u>		<u>St. Marys Cemetery</u>		<u>Silver Run, Carroll Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Harriet H. Miller</u>		<u>Richard A. Little</u>		<u>Littlestown, Pa.</u>	
DATE <u>11-20-56</u>							

BUREAU V. 3

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RECEIVED

PAID

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11203

11211 CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>				c. LENGTH OF STAY IN 1b <u>since 7-27-55</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City 24</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <u>116 Rochester Place</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Andrew</u> Last <u>Martin</u>				4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5 - 10 - 1878</u>	
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tile Setter</u>	
10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Benjamin Martin</u>	
14. MOTHER'S MAIDEN NAME <u>Mahn, Mary A. Bertha</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-18-6634</u>		17. INFORMANT <u>Records of Springfield State Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Edema of the lungs</u> <u>331 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebro-vascular accident</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>2 weeks</u> <u>2 years</u> <u>more than</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with cerebral arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____		(County) _____		(State) _____	
21. I certify that I attended the deceased from <u>Sept. 22</u> , 19 <u>55</u> , to <u>Novemb. 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Novemb. 11</u> , 19 <u>56</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>				DATE SIGNED <u>11-11-56</u>			
ACTUAL SIGNATURE <u>Martin Gross</u> M.D.				PHYSICIAN'S NAME (Type) <u>Martin Gross, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>				(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran-3000 E. Baltimore Street</u>				24a. REC'D BY REGISTRAR <u>NOV 14 1956</u>		24b. REGISTRAR'S SIGNATURE <u>C. Langley</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF CLERGYMAN		20. SIGNATURE OF BURIAL OFFICIAL		21. SIGNATURE OF FUNERAL HOME		22. SIGNATURE OF CEMETERY		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF SUPERVISOR	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF CLERGYMAN		28. SIGNATURE OF BURIAL OFFICIAL		29. SIGNATURE OF FUNERAL HOME		30. SIGNATURE OF CEMETERY		31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF SUPERVISOR	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF NEXT OF KIN		35. SIGNATURE OF CLERGYMAN		36. SIGNATURE OF BURIAL OFFICIAL		37. SIGNATURE OF FUNERAL HOME		38. SIGNATURE OF CEMETERY		39. SIGNATURE OF INTERVIEWER		40. SIGNATURE OF SUPERVISOR	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF CLERGYMAN		44. SIGNATURE OF BURIAL OFFICIAL		45. SIGNATURE OF FUNERAL HOME		46. SIGNATURE OF CEMETERY		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF SUPERVISOR	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF NEXT OF KIN		51. SIGNATURE OF CLERGYMAN		52. SIGNATURE OF BURIAL OFFICIAL		53. SIGNATURE OF FUNERAL HOME		54. SIGNATURE OF CEMETERY		55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF SUPERVISOR	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF NEXT OF KIN		59. SIGNATURE OF CLERGYMAN		60. SIGNATURE OF BURIAL OFFICIAL		61. SIGNATURE OF FUNERAL HOME		62. SIGNATURE OF CEMETERY		63. SIGNATURE OF INTERVIEWER		64. SIGNATURE OF SUPERVISOR	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF NEXT OF KIN		67. SIGNATURE OF CLERGYMAN		68. SIGNATURE OF BURIAL OFFICIAL		69. SIGNATURE OF FUNERAL HOME		70. SIGNATURE OF CEMETERY		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF SUPERVISOR	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF NEXT OF KIN		75. SIGNATURE OF CLERGYMAN		76. SIGNATURE OF BURIAL OFFICIAL		77. SIGNATURE OF FUNERAL HOME		78. SIGNATURE OF CEMETERY		79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF SUPERVISOR	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF CLERGYMAN		84. SIGNATURE OF BURIAL OFFICIAL		85. SIGNATURE OF FUNERAL HOME		86. SIGNATURE OF CEMETERY		87. SIGNATURE OF INTERVIEWER		88. SIGNATURE OF SUPERVISOR	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF NEXT OF KIN		91. SIGNATURE OF CLERGYMAN		92. SIGNATURE OF BURIAL OFFICIAL		93. SIGNATURE OF FUNERAL HOME		94. SIGNATURE OF CEMETERY		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF SUPERVISOR	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF NEXT OF KIN		99. SIGNATURE OF CLERGYMAN		100. SIGNATURE OF BURIAL OFFICIAL		101. SIGNATURE OF FUNERAL HOME		102. SIGNATURE OF CEMETERY		103. SIGNATURE OF INTERVIEWER		104. SIGNATURE OF SUPERVISOR	
105. SIGNATURE OF DECEASED		106. SIGNATURE OF NEXT OF KIN		107. SIGNATURE OF CLERGYMAN		108. SIGNATURE OF BURIAL OFFICIAL		109. SIGNATURE OF FUNERAL HOME		110. SIGNATURE OF CEMETERY		111. SIGNATURE OF INTERVIEWER		112. SIGNATURE OF SUPERVISOR	
113. SIGNATURE OF DECEASED		114. SIGNATURE OF NEXT OF KIN		115. SIGNATURE OF CLERGYMAN		116. SIGNATURE OF BURIAL OFFICIAL		117. SIGNATURE OF FUNERAL HOME		118. SIGNATURE OF CEMETERY		119. SIGNATURE OF INTERVIEWER		120. SIGNATURE OF SUPERVISOR	
121. SIGNATURE OF DECEASED		122. SIGNATURE OF NEXT OF KIN		123. SIGNATURE OF CLERGYMAN		124. SIGNATURE OF BURIAL OFFICIAL		125. SIGNATURE OF FUNERAL HOME		126. SIGNATURE OF CEMETERY		127. SIGNATURE OF INTERVIEWER		128. SIGNATURE OF SUPERVISOR	
129. SIGNATURE OF DECEASED		130. SIGNATURE OF NEXT OF KIN		131. SIGNATURE OF CLERGYMAN		132. SIGNATURE OF BURIAL OFFICIAL		133. SIGNATURE OF FUNERAL HOME		134. SIGNATURE OF CEMETERY		135. SIGNATURE OF INTERVIEWER		136. SIGNATURE OF SUPERVISOR	
137. SIGNATURE OF DECEASED		138. SIGNATURE OF NEXT OF KIN		139. SIGNATURE OF CLERGYMAN		140. SIGNATURE OF BURIAL OFFICIAL		141. SIGNATURE OF FUNERAL HOME		142. SIGNATURE OF CEMETERY		143. SIGNATURE OF INTERVIEWER		144. SIGNATURE OF SUPERVISOR	
145. SIGNATURE OF DECEASED		146. SIGNATURE OF NEXT OF KIN		147. SIGNATURE OF CLERGYMAN		148. SIGNATURE OF BURIAL OFFICIAL		149. SIGNATURE OF FUNERAL HOME		150. SIGNATURE OF CEMETERY		151. SIGNATURE OF INTERVIEWER		152. SIGNATURE OF SUPERVISOR	
153. SIGNATURE OF DECEASED		154. SIGNATURE OF NEXT OF KIN		155. SIGNATURE OF CLERGYMAN		156. SIGNATURE OF BURIAL OFFICIAL		157. SIGNATURE OF FUNERAL HOME		158. SIGNATURE OF CEMETERY		159. SIGNATURE OF INTERVIEWER		160. SIGNATURE OF SUPERVISOR	
161. SIGNATURE OF DECEASED		162. SIGNATURE OF NEXT OF KIN		163. SIGNATURE OF CLERGYMAN		164. SIGNATURE OF BURIAL OFFICIAL		165. SIGNATURE OF FUNERAL HOME		166. SIGNATURE OF CEMETERY		167. SIGNATURE OF INTERVIEWER		168. SIGNATURE OF SUPERVISOR	
169. SIGNATURE OF DECEASED		170. SIGNATURE OF NEXT OF KIN		171. SIGNATURE OF CLERGYMAN		172. SIGNATURE OF BURIAL OFFICIAL		173. SIGNATURE OF FUNERAL HOME		174. SIGNATURE OF CEMETERY		175. SIGNATURE OF INTERVIEWER		176. SIGNATURE OF SUPERVISOR	
177. SIGNATURE OF DECEASED		178. SIGNATURE OF NEXT OF KIN		179. SIGNATURE OF CLERGYMAN		180. SIGNATURE OF BURIAL OFFICIAL		181. SIGNATURE OF FUNERAL HOME		182. SIGNATURE OF CEMETERY		183. SIGNATURE OF INTERVIEWER		184. SIGNATURE OF SUPERVISOR	
185. SIGNATURE OF DECEASED		186. SIGNATURE OF NEXT OF KIN		187. SIGNATURE OF CLERGYMAN		188. SIGNATURE OF BURIAL OFFICIAL		189. SIGNATURE OF FUNERAL HOME		190. SIGNATURE OF CEMETERY		191. SIGNATURE OF INTERVIEWER		192. SIGNATURE OF SUPERVISOR	
193. SIGNATURE OF DECEASED		194. SIGNATURE OF NEXT OF KIN		195. SIGNATURE OF CLERGYMAN		196. SIGNATURE OF BURIAL OFFICIAL		197. SIGNATURE OF FUNERAL HOME		198. SIGNATURE OF CEMETERY		199. SIGNATURE OF INTERVIEWER		200. SIGNATURE OF SUPERVISOR	

BUREAU V. S.

NOV 8 1956

RECEIVED

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 FilmG207 11-26-56 et

CERTIFICATE OF DEATH

11205
74

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN b. 1yr. 1mo. 23 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 616 Melville Ave., Balto. 18, Md.			
3. NAME OF DECEASED (Type or print) First Charles Middle William Last McClinchey				4. DATE OF DEATH Month November Day 15 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1900		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John J. McClinchey				14. MOTHER'S MAIDEN NAME Annie Finley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Springfield State Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis of liver DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with alcohol intoxication without qualifying phrase.						INTERVAL BETWEEN ONSET AND DEATH Days Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 22, 1955 , to November 15, 1956 , that I last saw the deceased alive on November 15, 1956 , and that death occurred at 8:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/16/56 ACTUAL SIGNATURE Agustin del Campo M.D. PHYSICIAN'S NAME (Type) AGUSTIN DEL CAMPO Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/1956		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Greenworth Funeral				ADDRESS 4800 Liberty Heights Ave		24a. REC'D BY REGISTRAR NOV 19 1956	
				24b. REGISTRAR'S SIGNATURE C. Harry Karp			

BUREAU V. S.

NOV 19 1956

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11214

CERTIFICATE OF DEATH

11206

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b since 5-5-55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
f. STREET ADDRESS 1200 Valley Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Leonard Jerome Augustine MILLER				4. DATE OF DEATH Month November Day 15th Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-7-75	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months - Days -	IF UNDER 24 HRS. Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Albert Miller				14. MOTHER'S MAIDEN NAME Elizabeth -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records of Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia - right side 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gangrene of right lower leg DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with senile brain disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY a. m. _____ p. m. _____ Month, Day, Year ____ 19__	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____	(County) _____	(State) _____		
21. I certify that I attended the deceased from May 5 , 19 55 , to Nov. 15 , 19 56 , that I last saw the deceased alive on November 15th , 19 56 , and that death occurred at 5:00PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/16/56 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M. D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 19, 1956	22c. NAME OF CEMETERY OR CREMATORY Cathedral	22d. LOCATION (City, town, or county) (State) Baltimore, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Rita Wiedfeld 900 E. Biddle St.			24a. REC'D BY REGISTRAR NOV 19 1956	24b. REGISTRAR'S SIGNATURE C. Harry Wynn			

NOV 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11215 CERTIFICATE OF DEATH

Reg. Dist. No.

11207

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 31,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Ernest Last MITCHELL		4. DATE OF DEATH Month November Day 19, Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 7, 1888
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward E. Mitchell		14. MOTHER'S MAIDEN NAME Louise E. - ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Springfield Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease Years (c) Generalized arteriosclerosis Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.R.S. associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 9, 1955 to November 19, 1956 , that I last saw the deceased alive on November 19, 1956 , and that death occurred at 8:50A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/19/56	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 11-21-56	
22c. NAME OF CEMETERY OR CREMATORY Springfield		22d. LOCATION (City, town, or county) (State) Sykesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight - Sykesville, Md.		24a. REC'D BY REGISTRAR DATE 11-21-56	
24b. REGISTRAR'S SIGNATURE C. Harry Wuer			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Memphis, Tennessee	
7. CAUSE OF DEATH Suicide		8. MANNER OF DEATH Homicide		9. DISEASE OR INJURY Gunshot wound	
10. MEDICAL HISTORY None		11. PREVIOUS ILLNESS None		12. SURGICAL HISTORY None	
13. OCCUPATION None		14. EDUCATION None		15. RELIGION None	
16. MARITAL STATUS Single		17. SOCIAL HISTORY None		18. ALCOHOLIC HISTORY None	
19. TOBACCO HISTORY None		20. DRUG HISTORY None		21. OTHER HISTORY None	
22. SIGNATURE OF PHYSICIAN None		23. SIGNATURE OF CORONER None		24. SIGNATURE OF WITNESS None	
25. SIGNATURE OF DECEASED None		26. SIGNATURE OF NEXT OF KIN None		27. SIGNATURE OF OTHER None	

BUREAU V. 3
NOV 26 1968

RECEIVED

11216 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>Since 7.14.1921</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hosp</u>		d. STREET ADDRESS <u>215-2</u>	
3. NAME OF DECEASED (Type or print) <u>NANNIE</u> (First) <u>M.</u> (Middle) <u>MOSER</u> (Last)		4. DATE OF DEATH <u>11</u> Month <u>11</u> Day <u>1956</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5.10.1867</u> 89 yrs.
9. AGE (In years last birthday) <u>89</u>		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>
13. FATHER'S NAME <u>EZRA B. MOSER</u>		14. MOTHER'S MAIDEN NAME <u>ROSANNA WALLICK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>143 Washington Ave Hagerstown, Md.</u>	
17. INFORMANT <u>Mrs NANNIE M. HORN</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenia of Paranoid Type</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>Several years</u> <u>Many years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10.6</u> , 19 <u>56</u> to <u>11.11</u> , 19 <u>56</u> that I last saw the deceased alive on <u>11.11</u> , 19 <u>56</u> , and that death occurred at <u>12 noon</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Valdis Aizkrauklis M.D.</u>		ADDRESS (Street, city or town, state) <u>Springfield St. Hosp</u> DATE SIGNED <u>11.11.1956</u>	
PHYSICIAN'S NAME (Type) <u>VALDIS AIZKRAUKLIS M.D.</u>		<u>Sykesville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rural</u>	22b. DATE THEREOF <u>Nov. 14. 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Saharap Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>near Mahersville Arch. Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Best Funeral Home</u>		ADDRESS <u>Boonsboro Arch. Co. Md</u>	
24a. REC'D BY REGISTRAR <u>C. Harry Hays</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reissue carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. S.

NOV 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11217 CERTIFICATE OF DEATH

Reg. Dist. No. 1120974

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
c. LENGTH OF STAY IN 1b since 8/26/52				d. STREET ADDRESS 232 E. Church Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Virginia Middle Wolfe Last Null				4. DATE OF DEATH Month 11 Day 17 Year 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889, August 15		9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1936 Clerk				10b. KIND OF BUSINESS OR INDUSTRY Department Store		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Wolfe				14. MOTHER'S MAIDEN NAME Annie Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn		16. SOCIAL SECURITY NO. unkn		17. INFORMANT Hosp. Records & Son Ralph Null, Monongahela, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 455X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gangrenous decubitus ulcers DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome assoc. with cerebral arterioscler. with psych. react							INTERVAL BETWEEN ONSET AND DEATH hours weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-20- 19 54 , to 11-17- 19 56 , that I last saw the deceased alive on 11-17- 19 56 , and that death occurred at 6:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11-18-56 ACTUAL SIGNATURE Edmund Lusthaus PHYSICIAN'S NAME (Type) Edmund Lusthaus Sykesville, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 20 Nov 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 11-20-56		24b. REGISTRAR'S SIGNATURE C. Harry Warr	

U. S. DEPARTMENT OF JUSTICE

9561

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11218 CERTIFICATE OF DEATH

11210

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESTOWN				c. LENGTH OF STAY IN 1b SINCE 5-9-55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRINGFIELD STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
f. STREET ADDRESS 3316 LAKE AVE. BALTO				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNA Middle OLTEAN Last OLTEAN		4. DATE OF DEATH Month 11 Day 3 Year 1956		5. SEX F		6. COLOR OR RACE W.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH UNKNOWN		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) ROMANIA		12. CITIZEN OF WHAT COUNTRY? UNKNOWN	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT SSH. SOCIAL SERVICE. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO HYPERTENSION 443X DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) GENERALIZED ARTERIOSCLEROSIS. INTERVAL BETWEEN ONSET AND DEATH 1/2 HOUR YEARS YEARS.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRAIN SYNDROME ASSOCIATED WITH CEREBRAL ARTERIOSCLEROSIS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCTOBER, 1955 , to 11-3 , 19 56 , that I last saw the deceased alive on 11-3 , 19 56 , and that death occurred at 12:05 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Julian Radzykiewicz M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED			
PHYSICIAN'S NAME (Type) JULIAN RADZYKIENYCZ MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV 6-1956		22c. NAME OF CEMETERY OR CREMATORY OAKLAWN		22d. LOCATION (City, town, or county) (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Robert B. M. Walters ADDRESS 1444 S. Strickland St.				24a. REC'D BY REGISTRAR NOV 7 1956 24b. REGISTRAR'S SIGNATURE C. J. Hays			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

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11219

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 6yr, 11mo, 29dy		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS 1622 North Calvert Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joseph Middle Adams Last PINKLER			4. DATE OF DEATH Month November Day 7 Year 1956		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/6/93		9. AGE (In years last birthday) 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Unk -		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph P. Pinkler			14. MOTHER'S MAIDEN NAME Carrie Beck		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Springfield Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hemorrhage, right side 904.7 DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of skull, left side (c) Chronic brain syndrome associated with convulsive disorder with psychotic reaction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with convulsive disorder with psychotic reaction					INTERVAL BETWEEN ONSET AND DEATH 6 days 6 days
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient was found on floor unconscious			
20c. TIME OF INJURY Hour X o. m. 11/2 p. m. 19 56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/8/56	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11.10. 56	22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook Inc 1217 St. Paul Street Balto2 Md			24a. REC'D BY REGISTRAR 11-9-56		24b. REGISTRAR'S SIGNATURE C. Henry Allen

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NOV 15 1956

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NOV 15 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11220 CERTIFICATE OF DEATH

11212

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr. 1mo.; 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 518 S. Hanover Street	
3. NAME OF DECEASED (Type or print) First Charles Middle Samuel Last PLETZER		4. DATE OF DEATH Month November Day 2 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 10, 1905
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Pletzer		14. MOTHER'S MAIDEN NAME Annie Stevenson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1942-1943	
17. INFORMANT Springfield State Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced, active 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, paranoid type 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 15, 1955 to November 2, 1956 , that I last saw the deceased alive on November 1, 1956 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital	
DATE SIGNED 11/2/56			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-5-56	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J.D. Denny, Inc., 715 Light St., Balto., Md.		24a. REC'D. BY REGISTRAR NOV 5 1956	
24b. REGISTRAR'S SIGNATURE C. Denny			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 10, 1956	
AGE		SEX	
68		Male	
RACE		RELIGION	
White		Roman Catholic	
MARRIAGE		EDUCATION	
Married		High School	
OCCUPATION		PLACE OF BIRTH	
Retired		Baltimore, Maryland	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
DISEASE OR INJURY		PLACE OF DEATH	
Coronary Artery Disease		Home	
TIME OF DEATH		PLACE OF INTERMENT	
10:30 AM		St. Mary's Cemetery	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. Harris		J. H. Harris	
DATE		DATE	
JAN 10 1956		JAN 10 1956	

BUREAU V. &

NOV 5 1956

RECEIVED

11189

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN lb 10 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 92 PENNA. AVE.				d. STREET ADDRESS 92 PENNA. AVE.			
3. NAME OF DECEASED (Type or print) First MURTON Middle LEO Last REAUER				4. DATE OF DEATH Month Nov Day 1 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 28, 1900		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION Co. FRED. CO. Md.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME M. HAMILTON REAUER				14. MOTHER'S MAIDEN NAME FLORENCE HAINES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-18-2365		17. INFORMANT Address MRS. LEO REAUER, WESTMINSTER, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 5 min	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh EXAMINER'S NAME (Type) JAMES T. MARSH				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/1/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 3, 1956		22c. NAME OF CEMETERY OR CREMATORY WESTMINSTER CEMETERY		22d. LOCATION (City, town, or county) (State) WESTMINSTER, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. S. Major, Jr., Westminster, Md.				24a. REC'D BY REGISTRAR DATE 11-2-56		24b. REGISTRAR'S SIGNATURE Harriet Miller	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

NOV 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11221 CERTIFICATE OF DEATH

11214
74

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenelg			
				d. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print) First Warren Middle Thomas Last RIDGLEY				4. DATE OF DEATH Month November Day 19 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 19, 1881	9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Ridgley				14. MOTHER'S MAIDEN NAME Mary -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk		17. INFORMANT Address Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) General arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH Hours Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 6, 1956 , to November 19, 1956 , that I last saw the deceased alive on November 19, 1956 , and that death occurred at 1:33P M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 11/19/56	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-56		22c. NAME OF CEMETERY OR CREMATORY Harmony		22d. LOCATION (City, town, or county) (State) Howard Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight, Sykesville, Md.				24a. REC'D BY REGISTRAR DATE 11-20-56		24b. REGISTRAR'S SIGNATURE C. Harry Weaver	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		MARRIAGE	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
DISEASE OR INJURY		MANNER OF DEATH		PLACE OF INTERMENT		DATE OF INTERMENT		NAME OF INTERMENT	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF DECEASED	
DATE		TIME		PLACE		CITY		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.		RECEIVED	
BUREAU V. 2		OCT 23 1956		RECEIVED		FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE	
DATE		TIME		PLACE		CITY		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.		RECEIVED	
BUREAU V. 2		OCT 23 1956		RECEIVED		FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11222 CERTIFICATE OF DEATH

11215 82

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u>	c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Park Avenue</u>		d. STREET ADDRESS <u>Park Avenue</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Rinker</u> Last <u>Rinker</u>		4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 4, 1867</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>9</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>? Lanom</u>	
14. MOTHER'S MAIDEN NAME <u>? UNKNOWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>	
16. SOCIAL SECURITY NO. <u>-None-</u>		17. INFORMANT <u>Mrs. Anna Mae Fowler - Mt. Airy, Md.</u> (Daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>July</u> , 1956, to <u>November, 1956</u> , that I last saw the deceased alive on <u>November 21, 1956</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.		ADDRESS (Street, city or town, state) <u>Mt. Airy, Md.</u> DATE SIGNED <u>Nov 27, 1956</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-30-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>	22d. LOCATION (City, town, or county) (State) <u>Mt. Airy, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. Waitz,</u>		ADDRESS <u>Winfield, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 29 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Edna Hewitt</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. JONES</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>Nov 28 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Retired</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SIGNATURE OF PHYSICIAN <i>Dr. J. J. Jones</i>	
16. SIGNATURE OF DECEASED <i>None</i>		17. SIGNATURE OF WITNESSES <i>None</i>		18. SIGNATURE OF REGISTRAR <i>None</i>	

BUREAU V. 1

NOV 29 1956

RECEIVED

11223 CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Adams</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mar Chester</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Berlin</u> 75 X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>			d. STREET ADDRESS <u>R R D #1</u>		
3. NAME OF DECEASED (Type or print) <u>Emma Catherine Sebright</u> First Middle Last			4. DATE OF DEATH <u>November 8</u> Month Day Year 19 <u>56</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1865</u>		9. AGE (In years last birthday) <u>91</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Lewis Ketter</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Soder</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Mrs. John Crawford</u> Address <u>Hannover Pa</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Certain selective Cardis - Paul Vas. Disease</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>July 26</u> , 19 <u>55</u> , to <u>Nov 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 8</u> , 19 <u>56</u> , and that death occurred at <u>12:10 P</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.			ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>11-8-56</u>		
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>			HAMPSTEAD Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 11/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East Berlin cem</u>		22d. LOCATION (City, town, or county) (State) <u>Adams Co Md Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Tipton</u> ADDRESS <u>Hampstead Md</u>			24a. REC'D BY REGISTRAR <u>Mrs. HPL-Danner</u> DATE <u>Nov. 10-56</u>		24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 14 1956

RECEIVED

11224 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>				c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>E</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-1899</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Earl Jenkins</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Jose E. Smith - Sykesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAL Arrest, CORONARY Thrombosis.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, Obesity.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>26 hrs</u> to <u>27 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>56</u> , to <u>27 Nov</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>27 Nov</u> , 19 <u>56</u> , and that death occurred at <u>6:45 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u> DATE SIGNED <u>27 Nov 56</u>			
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>				ADDRESS <u>SYKESVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Granite Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Granite, Balt. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Haight</u> ADDRESS <u>Sykesville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>11-28-56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Weir</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11225

Item 2, Film G207, 11/23/56 bh

CERTIFICATE OF DEATH

11218

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELSIE</u> First <u>R.</u> Middle <u>SMITH</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9.27.1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DANIEL J. ROBERTS</u>		14. MOTHER'S MAIDEN NAME <u>LAURA RENS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>535 Piccadilly</u> <u>Mrs William L. RICHARDS ON Balto 4, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Non-specific Myocardial Disease</u> <u>and Pleurisy Left Side.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Manic Depressive Psychosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>Several years</u> <u>8 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-25</u> , 19 <u>41</u> , to <u>11-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-10</u> , 19 <u>56</u> , and that death occurred at <u>1 p.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gertrud Souweafeldt</u> M.D.		ADDRESS (Street, city or town, state) <u>Springfield State Hospital "A."</u>	
PHYSICIAN'S NAME (Type) <u>Gertrud Souweafeldt M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>11/13/56</u>	<u>Woodlawn Cmn</u>	<u>Woodlawn, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Tiekner & Sons</u>		24. REGD BY REGISTRAR <u>DATE Nov 18, 1956</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>C. Harry Keen</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. ROBERTS</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>NOV 14 1955</i>		5. TIME OF DEATH <i>10:15 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>		9. PLACE OF BIRTH <i>BALTIMORE, MD</i>	
10. OCCUPATION <i>CLERK</i>		11. MARITAL STATUS <i>MARRIED</i>		12. EDUCATION <i>HIGH SCHOOL</i>	
13. PREVIOUS ILLNESS <i>NO</i>		14. PRESENT ILLNESS <i>NO</i>		15. MEDICAL HISTORY <i>NO</i>	
16. PHYSICIAN'S SIGNATURE <i>[Signature]</i>		17. COUNTY HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		18. STATE HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>	
19. COUNTY HEALTH OFFICER'S NAME <i>JOHN J. ROBERTS</i>		20. STATE HEALTH OFFICER'S NAME <i>JOHN J. ROBERTS</i>		21. COUNTY HEALTH OFFICER'S ADDRESS <i>1234 MAIN ST, BALTIMORE, MD</i>	
22. STATE HEALTH OFFICER'S ADDRESS <i>1234 MAIN ST, BALTIMORE, MD</i>		23. COUNTY HEALTH OFFICER'S PHONE <i>123-4567</i>		24. STATE HEALTH OFFICER'S PHONE <i>123-4567</i>	
25. COUNTY HEALTH OFFICER'S TITLE <i>CLERK</i>		26. STATE HEALTH OFFICER'S TITLE <i>CLERK</i>		27. COUNTY HEALTH OFFICER'S EMPLOYER <i>STATE DEPARTMENT OF HEALTH</i>	
28. STATE HEALTH OFFICER'S EMPLOYER <i>STATE DEPARTMENT OF HEALTH</i>		29. COUNTY HEALTH OFFICER'S EMPLOYER <i>STATE DEPARTMENT OF HEALTH</i>		30. STATE HEALTH OFFICER'S EMPLOYER <i>STATE DEPARTMENT OF HEALTH</i>	

BUREAU V. 5

NOV 14 1955

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11226

Reg. Dist. No.

71

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNIONTOWN RURAL</u>		c. LENGTH OF STAY IN lb <u>2 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>604 WARREN AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUSSELL MOSES SMITH</u>		4. DATE OF DEATH Month Day Year <u>NOV 24 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 8 - 1932</u>
9. AGE (In years last birthday) <u>24 yrs.</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK HELPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY TRUCKS</u>	11. BIRTHPLACE (State or foreign country) <u>CARROLL CO. MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>MERTON THOMAS</u>	
14. MOTHER'S MAIDEN NAME <u>SARAH FRITZ</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>217-30-6616</u>		17. INFORMANT <u>BETTY SMITH</u> Address <u>LANDOVER MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT WOUND 7 head</u> <u>919.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>NONE</u>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>GUNSHOT - ACCIDENTAL - HUNTING</u>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>11-24 1956</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>FARM</u>
20f. (City or town) (County) (State) <u>Uniontown Carroll Md</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James J. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/25/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV 27 - 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u>	22d. LOCATION (City, town, or county) (State) <u>UNIONTOWN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartglow & Sons, New Windsor, Md</u>		24a. REC'D BY REGISTRAR DATE <u>11 28 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Margaret Engle</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 3 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File together with 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The form is mostly blank with some faint markings.

RECEIVED
NOV 28 1956
BUREAU V. 2

11227 CERTIFICATE OF DEATH

Reg. Dist. No.

75

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Lineboro</u>		c. LENGTH OF STAY IN 1b <u>65 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Lineboro</u>		d. STREET ADDRESS <u>R.D.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Levi H. Sotdorus</u>				4. DATE OF DEATH Month Day Year <u>November 22 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 12 1868</u>	9. AGE (In years last birthday) yrs. <u>88</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Glen Rock, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm H. Sotdorus</u>				14. MOTHER'S MAIDEN NAME <u>Leah Ehrman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs. Sarah Sotdorus Lineboro Md R.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Disease</u> <u>Arteriosclerotic</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 10, 1956</u> , to <u>Nov 22, 1956</u> , that I last saw the deceased alive on <u>Nov 15, 1956</u> , and that death occurred at <u>12:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Paul D. Shaub</u> M.D. <u>Shrewsbury, Pa.</u> <u>11-24-56</u> PHYSICIAN'S NAME (Type) <u>Paul D. Shaub</u> <u>Shrewsbury, Pa.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 25 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Steltz Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Rock Pa. R.D. 3</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Jacob Hartenstein</u>				ADDRESS <u>New Freedom Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 27 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. H. R. S. Sotdorus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1152

1152

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Nov 15 1956</i>		TIME OF DEATH <i>10:30 AM</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		LOCALITY OF DEATH <i>City of Baltimore</i>	
DECEASED'S RESIDENCE <i>123 Main St</i>		DECEASED'S OCCUPATION <i>Teacher</i>		DECEASED'S MARITAL STATUS <i>Married</i>		DECEASED'S RELIGION <i>Catholic</i>	
DECEASED'S BIRTH DATE <i>Jan 1 1911</i>		DECEASED'S BIRTH PLACE <i>MD</i>		DECEASED'S EDUCATION <i>High School</i>		DECEASED'S SERVICE <i>None</i>	
DECEASED'S SOCIAL SECURITY NO. <i>123-45-6789</i>		DECEASED'S MOTHER'S MAIDEN NAME <i>Smith</i>		DECEASED'S FATHER'S NAME <i>John Doe</i>		DECEASED'S SPOUSE'S NAME <i>Jane Doe</i>	
DECEASED'S NEXT OF KIN <i>John Doe</i>		DECEASED'S NEXT OF KIN ADDRESS <i>123 Main St</i>		DECEASED'S NEXT OF KIN CITY <i>Baltimore</i>		DECEASED'S NEXT OF KIN STATE <i>MD</i>	
DECEASED'S NEXT OF KIN PHONE NO. <i>123-4567</i>		DECEASED'S NEXT OF KIN OCCUPATION <i>Teacher</i>		DECEASED'S NEXT OF KIN MARRIAGE <i>Married</i>		DECEASED'S NEXT OF KIN RELIGION <i>Catholic</i>	
DECEASED'S NEXT OF KIN BIRTH DATE <i>Jan 1 1911</i>		DECEASED'S NEXT OF KIN BIRTH PLACE <i>MD</i>		DECEASED'S NEXT OF KIN EDUCATION <i>High School</i>		DECEASED'S NEXT OF KIN SERVICE <i>None</i>	
DECEASED'S NEXT OF KIN SOCIAL SECURITY NO. <i>123-45-6789</i>		DECEASED'S NEXT OF KIN MOTHER'S MAIDEN NAME <i>Smith</i>		DECEASED'S NEXT OF KIN FATHER'S NAME <i>John Doe</i>		DECEASED'S NEXT OF KIN SPOUSE'S NAME <i>Jane Doe</i>	
DECEASED'S NEXT OF KIN NEXT OF KIN <i>John Doe</i>		DECEASED'S NEXT OF KIN NEXT OF KIN ADDRESS <i>123 Main St</i>		DECEASED'S NEXT OF KIN NEXT OF KIN CITY <i>Baltimore</i>		DECEASED'S NEXT OF KIN NEXT OF KIN STATE <i>MD</i>	
DECEASED'S NEXT OF KIN NEXT OF KIN PHONE NO. <i>123-4567</i>		DECEASED'S NEXT OF KIN NEXT OF KIN OCCUPATION <i>Teacher</i>		DECEASED'S NEXT OF KIN NEXT OF KIN MARRIAGE <i>Married</i>		DECEASED'S NEXT OF KIN NEXT OF KIN RELIGION <i>Catholic</i>	
DECEASED'S NEXT OF KIN NEXT OF KIN BIRTH DATE <i>Jan 1 1911</i>		DECEASED'S NEXT OF KIN NEXT OF KIN BIRTH PLACE <i>MD</i>		DECEASED'S NEXT OF KIN NEXT OF KIN EDUCATION <i>High School</i>		DECEASED'S NEXT OF KIN NEXT OF KIN SERVICE <i>None</i>	
DECEASED'S NEXT OF KIN NEXT OF KIN SOCIAL SECURITY NO. <i>123-45-6789</i>		DECEASED'S NEXT OF KIN NEXT OF KIN MOTHER'S MAIDEN NAME <i>Smith</i>		DECEASED'S NEXT OF KIN NEXT OF KIN FATHER'S NAME <i>John Doe</i>		DECEASED'S NEXT OF KIN NEXT OF KIN SPOUSE'S NAME <i>Jane Doe</i>	

BUREAU V. S.

NOV 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11228 CERTIFICATE OF DEATH

11221

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE		c. LENGTH OF STAY IN 1b YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ELGER ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR ELLSWORTH WILSON		4. DATE OF DEATH NOV 20 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 15-1873
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY TENANT	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACOB WILSON		14. MOTHER'S MAIDEN NAME JENNIE WILSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-24-1458	
17. INFORMANT STERLING WILSON		Address UNION BRIDGE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-16 , 19 56 , to 11-19 , 19 56 , that I last saw the deceased alive on 11-19 , 19 56 , and that death occurred at 12:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. H. Legg		ADDRESS (Street, city or town, state) Union Bridge MD	
PHYSICIAN'S NAME (Type) J. H. LEGG		DATE SIGNED 11-19-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV 22-1956	
22c. NAME OF CEMETERY OR CREMATORY BEAVER DAM		22d. LOCATION (City, town, or county) (State) FREDERICK CO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE D. D. Hartzler & Sons		ADDRESS Union Bridge Md	
24a. REC'D BY REGISTRAR NOV 26 1956		24b. REGISTRAR'S SIGNATURE Leslie L. Repp	

BUREAU V. S.

3961 92-10M

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11229

CERTIFICATE OF DEATH

Reg. Dist. No.

11222

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Henryton State Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>			
				d. STREET ADDRESS <u>Duckett Lane, Box 356</u>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Seward</u> Last <u>Woolford, Jr.</u>				4. DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/14/1902</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Elkridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel S. Woolford, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Barner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Samuel S. Woolford, Jr.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far Advanced Bilateral Pulmonary Tuberculosis with bilateral cavitations.</u> DUE TO (b) <u>Cardiac Insufficiency.</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 Yr.(?)</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 7, 1956</u> , to <u>Nov. 9, 1956</u> , that I last saw the deceased alive on <u>Nov. 9, 1956</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. F. Vestal</u>		ADDRESS (Street, city or town, state) <u>Henryton, Md.</u>					
PHYSICIAN'S NAME (Type) <u>T. F. Vestal</u>		DATE SIGNED <u>Henryton, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert R. Swankhouse</u>				ADDRESS <u>Baltimore, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/10/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Albert R. Swankhouse</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN lb 1yr;2mos;12days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle Frederick Last WRIGHT				4. DATE OF DEATH Month November Day 14 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1875		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Frederick Wright				14. MOTHER'S MAIDEN NAME Nell Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Springfield Hospital records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0 (b) Right pulmonary artery embolism DUE TO (c) Arteriosclerotic heart disease 902.7							INTERVAL BETWEEN ONSET AND DEATH 2 - 3 days. Minutes Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. asso. with circ. disturb. with cereb. arteriosclerosis with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of bed.					
20c. TIME OF INJURY Month, Day, Year 4:30 p. m. 11/3/56 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James T. Marsh</i>				DATE SIGNED Nov. 15, 1956.			
EXAMINER'S NAME (Type) James T. Marsh, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-17-56		22c. NAME OF CEMETERY OR CREMATORY Mt. View		22d. LOCATION (City, town, or county) (State) Alpha, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR NOV 19 1956			
				24b. REGISTRAR'S SIGNATURE <i>C. Harry Steers</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NOV 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11224

11231 CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster P.O.#5</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Westminster Road</u>		d. STREET ADDRESS <u>Westminster Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HELEN LOUISE YOUNG</u>		4. DATE OF DEATH <u>Nov. 19 1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 5, 1905</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house - wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York City N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Byron Gray Warner</u>		14. MOTHER'S MAIDEN NAME <u>Helma Weiss</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Carroll J. Young, Westminster Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leucemia</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Leucemia with failure lung.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Months - 1 year +.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Sclerosis.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 1955, to <u>Nov. 19</u> , 1956, that I last saw the deceased alive on <u>Nov. 16</u> , 1956, and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James J. Marsh</u>		ADDRESS (Street, city or town, state) <u>107 E. Main St. Westminster Md.</u>	
M.D. <u>107 E. Main St.</u>		DATE SIGNED <u>11/20/56</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 23, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Medow Brook Cemetery Rural, Westminster Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Myers, Jr., Westminster Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>11-22-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harold Muller</u>	

BUREAU V. S.

NOV 26, 1956

RECEIVED